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Special Education and Mental Health: Closing the Gap

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Abstract

Students with disabilities are disproportionately affected by co-occurring mental health conditions, yet these needs are often overshadowed by primary diagnoses and treated solely as behavioral concerns. This commentary highlights the urgent need to integrate mental health supports into special education by aligning policy and practice within collaborative school-wide systems of support. Promising practices and recommendations for teacher support are discussed.

Keywords: Special education, Mental health, School-based providers, Multi-tiered systems of support, Students with disabilities

Introduction

Current data indicate that approximately 20% of youth will experience substantial mental health difficulties during their time in school [1], a trend that is becoming more prominent post-pandemic. According to the National Institute of Mental Health [2], nearly 70% of children with special needs also experience co-occurring mental health conditions, such as anxiety, depression, or mood disorders. For many of them, these mental health challenges often go unrecognized behind their primary diagnosis or are mistaken for behavioral issues and left untreated [3]. This commentary, based on the book chapter *Mental Health and Students with Special Needs* [4], highlights the critical intersection between mental health and special education. Despite increasing awareness of students' overlapping needs, mental health symptoms are often overlooked or mistaken for part of the learner's disability. It's time to rethink how we respond to mental health challenges for students with disabilities by examining frameworks that integrate mental health supports into practice, policy, and training.

Students with Disabilities and Mental Health

Students with special needs represent a diverse group of learners who require additional and specialized support due to physical, cognitive, emotional, and/or developmental differences [5]. The Individuals with Disabilities Education Act (IDEA, 2004) [6] mandates equitable educational access and programming for students with special needs. This law offers protections to various categories of students with special needs, including students with developmental disabilities (e.g., autism spectrum disorder or Down syndrome); learning disabilities (e.g., dyslexia); intellectual disabilities (e.g., below-average cognitive functioning); and emotional disabilities (e.g., internalizing and externalizing behavioral challenges). IDEA also includes students with speech and language impairments, sensory deficits, and physical and motor disabilities [6]. While students with special needs receive primarily academic and developmental support through this law, their underlying co-occurring mental health needs are frequently overlooked.

In the current landscape, mental health and special education are often viewed as distinct professional fields [7]. Mental health is the state of a person's psychological and emotional well-being that equips them to handle life's stressors [8]. Special education, on the other hand, primarily addresses academic and behavioral challenges directly linked to a student's diagnosed disability, often overlooking

underlying emotional or psychological distress [9]. While school-based mental health services are gaining ground, their reach remains limited [9]. Furthermore, student behavior is typically seen through a disciplinary lens, rather than as a symptom of anxiety, depression, or trauma. Research indicates that students with special needs are significantly more likely to grapple with co-occurring mental health conditions such as anxiety, depression, post-traumatic stress disorder (PTSD), or mood disorders than their peers without disabilities [3,9]. Due to diagnostic overshadowing, preexisting special education identification or primary disability often leads to misinterpretation of symptoms of mental health challenges and emotional distress [10]. Many students with special needs face heightened social stressors, such as bullying, alienation, or adverse childhood experiences, which further escalate their mental health risks [11]. These challenges are compounded by the fact that mental health and special education professionals may operate in isolation, with limited communication and collaboration, making it difficult for students with special needs to receive integrated, coordinated care [12]. Without deliberate efforts to address this, we fail to support the whole child: academically, socially, and emotionally.

The Current State of Mental Health Support in Schools

In recent years, there has been a growing recognition of the critical need to integrate mental health into special education practices [9]. The COVID-19 pandemic highlighted the importance of the emotional and mental well-being of children with disabilities and their families. Whole child frameworks and trauma-informed practices are becoming more prevalent in schools. The adoption of Multi-Tiered Systems of Support (MTSS) involves early identification of mental health concerns and coordinated interventions within a tiered continuum of care [13]. Some districts have begun embedding mental health professionals into special education teams, ensuring that emotional and behavioral needs are addressed alongside academic and behavioral goals [14]. Policy discussions are also evolving, with greater emphasis on incorporating social-emotional learning (SEL) and mental well-being goals into students' individual education plans (IEPs) [14]. While these shifts are promising, progress remains inconsistent across regions and often depends on available resources, funding, and training [13]. Still, the momentum toward multi-tiered, integrated, and culturally responsive support offers hope for more inclusive and integrated systems.

Promising Practices and Models

By centering student mental health within MTSS and integrating trauma-informed and culturally responsive approaches, we can align best practices in both special education and school mental health research [15]. MTSS frameworks allow school teams to move beyond isolated approaches to provide wraparound services within a tiered continuum of care. Tier I supports are universal supports, such as positive behavior interventions and supports (PBIS), school climate initiatives, SEL, and basic classroom management strategies [16]. These supports are foundational for prevention, but may not be comprehensive enough for all learners. Schoolwide mental health screening and a data-driven referral program help identify students who need more intensive supports [16]. Tier II and III supports focus on targeted and intensive interventions to ensure students with higher needs receive individualized services, such as social skills instruction, counseling, check-in systems, and wraparound services [16]. This progression mirrors evidence-based models in school mental health literature, which underscore the importance of early identification, data-driven decision making, and tiered escalation of supports [12].

MTSS frameworks recognize the critical role that school-based mental health professionals (such as nurses, counselors, school psychologists, and social workers) serve on MTSS teams. In partnership with school administrators, teachers, parents, and other educational stakeholders, school-based mental health professionals serve as both direct service providers and experts in assessment, early identification, intervention, and treatment [17]. These professionals play an active role in the effective implementation of MTSS in several ways, Including:

- Conducting screenings and assessments
- Supporting in differentiating between disability-related behaviors and emerging mental health concerns
- Developing crisis response plans
- Delivering group and individual counseling sessions
- Coordinating wraparound services
- Coaching teachers in SEL strategies
- Promoting trauma-informed practices and policies [17]

In these ways and more, mental health professionals serve as key team members, ensuring that the MTSS framework functions effectively to support students.

School-Based Mental Health Service Implementation

Implementing robust mental health services within the realities of schools is complex. In this context, there are considerable barriers to students receiving mental health care, from a lack of funding to the historic oppression of marginalized groups and logistical challenges brought on by staffing shortages [18]. MTSS teams are composed of individuals with interdisciplinary knowledge and experiences to combat those barriers by collaborating effectively and

efficiently. To make the most of available resources within a complex reality, schools have turned to two innovative delivery models: co-locating mental health providers in schools [19] and developing wraparound services that prioritize collaboration to meet student needs [20].

Co-located mental health providers are licensed professionals who are physically located and integrated within a school campus. Instead of requiring students to travel to an external clinic or office for mental health services, these professionals offer their services directly at the school [19]. Co-location differs from traditional school-based mental health services in that the resources of a mental health location, not just the professionals themselves, are permanently based at the school [19]. This structural change can lead to increased sharing of resources, prioritization of accessible mental health services within the school, and building crucial working relationships within the MTSS team. The power of two institutions comes together here to enable access.

In addition to co-locating, schools have prioritized wraparound services to integrate mental health services. Wraparound services are a comprehensive approach to supporting students and their families by addressing academic, social, emotional, and health-related needs [20,21]. A wraparound team typically includes school staff, mental health providers, family members, any additional community services, and the student. In 1996, early research on wraparound services established the intent for all stakeholders to be included in designing an individualized, culturally responsive, family-driven, and student-centered plan to dismantle barriers to student success [20]. Services may include housing assistance, transportation, tutoring, vocational training, and mental health services. The goal is to create a circle of support around the student to remove obstacles to their success, to empower them to thrive both inside and outside of the classroom, ultimately leading to improved school attendance, academic achievement, and overall well-being [21].

These programs, whether wraparound or co-located providers, have the most impact when professionals, students, and community members are authentically collaborating with all stakeholders [19,20]. After all, if mental health services truly seek to serve students with disabilities, then they must fully integrate into the existing cultures and communities. For example, an Australian study describes a co-designed Community Hub located at a high school in an area with high needs and low access to services [22]. Here, the designers of the Hub are the people who will use, implement, and benefit from the end product. Through collaborative design, the intent is to cultivate an inclusive program that is authentically entrenched in community values, leading to higher usage and buy-in. In this specific study, the participants created a third space through the Community Hub. In the context of co-located mental health services in schools, third spaces are places that bridge home, school, and clinical settings [23]; they often feel less formal, prioritize recognition of shared values and diversity, provide inclusive spaces for all, and offer readily available resources for stakeholders. Third spaces are significant for students experiencing oppression who are more likely to experience substantial barriers to services [22,23].

Policy and Practice Recommendations

Section 504 (1973) and IDEA (2004) mandate the protection of the rights of students with disabilities, including mental health needs [6,24]. Through an IEP or a 504 plan, students may receive counseling, accommodations, and other mental health supports. Local education agencies must ensure that special education teachers are supported in writing these components of the IEP, and that teachers have a clear grasp of available supports [6]. Further, school teams should ensure that their policies and procedures actively integrate mental health considerations into the special education process, including clear referral pathways, data-driven decision-making, and collaboration with parents and families [7,9,17]. Co-designing wraparound services is one method to ensure that students have comprehensive access to robust services that address the needs of the student and their family [21].

Meaningful school mental health professional participation in these special education processes requires availability for consistent collaboration; however, persistent staffing shortages often limit the capacity of schools to provide these comprehensive supports [18]. The American School Counselor Association recommends a ratio of less than 250 students per counselor [25]. In 2024, just three states (Vermont, New Hampshire, and Hawaii) met this standard, while several states reported student-to-counselor ratios nearing or exceeding 500:1, more than double the recommended threshold [26]. As schools face staffing shortages and reduced funding, the risk of insufficient service provision and overburdening teachers without adequate support remains a significant concern. Researchers should explore scalable models such as telehealth, task shifting, and community partnerships [17]. Co-locating mental health providers, as previously described, is another pathway to share resources and increase the level of immediate mental health support for students and teachers [19]. Advocating for policy initiatives to secure sustainable funding will be necessary to continue to support the increasing mental health needs of students.

Limited availability of such professionals underscores the need for teachers and other school staff to receive training in tiered, classroom-level interventions that can bridge immediate gaps in student support [27]. Many states require mandated professional development on topics related to mental health, including suicide prevention, violence, bullying, and mandated reporting. Further, training in trauma-informed practices that are culturally responsive

allows teachers to prevent the re/traumatization of students in their classrooms [28]. Despite well-intended individuals working to support students, institutions like schools are often entrenched in oppression (e.g., ableism, racism) dating back generations [29,30]. Trauma-informed practices and cultural responsiveness trainings are essential initial steps to proactively reduce harm in classrooms and cultivate impactful relationships with families and community members [27]. Teachers, however, cannot dismantle systemic barriers and provide services alone. They need the crucial expertise that mental health professionals bring to meet the needs of students fully.

Conclusion

Meaningful integration of mental health support in the context of special education requires clear systems, policies, and procedures focused on systematic screening, on-demand access to services, and sustained collaboration within MTSS frameworks. This commentary highlights the need for alignment across disciplines to ensure that disability *and* mental health–related needs are addressed comprehensively. However, successful implementation is contingent on sufficient funding to sustain service models that are adequate to meet the growing needs of school-aged children. Mental health professionals, educators, community members, researchers, and administrators must demand that the mental health of students with disabilities be a priority and hold leaders accountable for allocating the necessary funding. Further, updates to outdated legislation, such as IDEA, which was last reauthorized in 2004, are overdue. Advancing research and policy is essential to ensure that students with disabilities receive effective and equitable support.

Conflicts of Interest

None to report.

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